



## Senate

General Assembly

**File No. 289**

January Session, 2009

Substitute Senate Bill No. 823

*Senate, March 30, 2009*

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

### ***AN ACT CONCERNING REVISIONS TO THE INSURANCE STATUTES.***

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Subsection (d) of section 38a-8 of the general statutes is  
2 repealed and the following is substituted in lieu thereof (*Effective*  
3 *October 1, 2009*):

4 (d) The commissioner shall develop a program of periodic review to  
5 ensure compliance by the Insurance Department with the minimum  
6 standards established by the National Association of Insurance  
7 Commissioners for effective financial surveillance and regulation of  
8 insurance companies operating in this state. The commissioner shall  
9 adopt regulations, in accordance with the provisions of chapter 54,  
10 pertaining to the financial surveillance and solvency regulation of  
11 insurance companies and health care centers as are reasonable and  
12 necessary to obtain or maintain the accreditation of the Insurance  
13 Department by the National Association of Insurance Commissioners.  
14 The commissioner shall maintain, as confidential, any confidential  
15 documents or information received from the National Association of

16 Insurance Commissioners, or the International Association of  
17 Insurance Supervisors, or any documents or information received from  
18 state or federal insurance, banking or securities regulators or similar  
19 regulators in a foreign country which are confidential in such  
20 jurisdictions. The commissioner may share any information, including  
21 confidential information, with the National Association of Insurance  
22 Commissioners, the International Association of Insurance  
23 Supervisors, or state or federal insurance, banking or securities  
24 regulators or similar regulators in a foreign country so long as the  
25 commissioner determines that such entities agree to maintain the same  
26 level of confidentiality in their jurisdiction as is available in this state.  
27 The commissioner may engage the services of, at the expense of a  
28 domestic, alien or foreign insurer or other entity requiring licensure or  
29 registration pursuant to title 38a, attorneys, actuaries, accountants and  
30 other experts not otherwise part of the commissioner's staff as may be  
31 necessary to assist the commissioner in the financial analysis of the  
32 insurer or other entity, the review of the insurer's or other entity's  
33 license and registration applications, and the review of transactions  
34 within a holding company system involving an insurer domiciled in  
35 this state. No duties of a person employed by the Insurance  
36 Department on November 1, 2002, shall be performed by such  
37 attorney, actuary, accountant or expert.

38 Sec. 2. Section 38a-9 of the general statutes is repealed and the  
39 following is substituted in lieu thereof (*Effective from passage*):

40 (a) Notwithstanding the provisions of section 4-8, there shall be a  
41 [Division of Consumer Affairs] division within the Insurance  
42 Department [, which division] that shall act on the Insurance  
43 Commissioner's behalf and at his direction in order to carry out his  
44 responsibilities under this title with respect to [such] consumer and  
45 market conduct matters. The division shall receive and review  
46 complaints from residents of this state concerning their insurance  
47 problems, including claims disputes, and serve as a mediator in such  
48 disputes in order to assist the commissioner in determining whether  
49 statutory requirements and contractual obligations within the

50 commissioner's jurisdiction have been fulfilled. There shall be a  
51 director of said division, who shall be provided with sufficient staff.  
52 The division shall serve to coordinate all appropriate facilities in the  
53 department in addressing such complaints, and conduct any outreach  
54 programs deemed necessary to properly inform and educate the public  
55 on insurance matters. The director shall submit quarterly reports to the  
56 commissioner, which shall state the number of complaints received by  
57 the division in such calendar quarter, the Connecticut premium  
58 volume of the appropriate line of each insurance company against  
59 which a complaint has been filed, the types of complaints received,  
60 and the number of such complaints which have been resolved. Such  
61 reports shall be published every six months and copies shall be made  
62 available to any interested resident of this state upon request. The  
63 commissioner shall report to the joint standing committee of the  
64 General Assembly having cognizance of matters relating to insurance  
65 on or before January 15, 1988, and annually thereafter, concerning the  
66 findings of such reports and suggestions for legislative initiatives to  
67 address recurring problems.

68 (b) (1) The [Division of Consumer Affairs] division set forth in  
69 subsection (a) of this section shall provide an independent arbitration  
70 procedure for the settlement of disputes between claimants and  
71 insurance companies concerning automobile physical damage and  
72 automobile property damage liability claims in which liability and  
73 coverage are not in dispute. Such procedure shall apply only to  
74 disputes involving private passenger motor vehicles as defined in  
75 subsection (e) of section 38a-363. Any company licensed to write  
76 private passenger automobile insurance, including collision,  
77 comprehensive and theft, in this state shall participate in the  
78 arbitration procedure. The commissioner shall appoint an  
79 administrator for such procedure. Only those disputes in which  
80 attempts at mediation by [the Division of Consumer Affairs] such  
81 division have failed shall be accepted as arbitrable. The referral of the  
82 complaint to arbitration shall be made by the Insurance Department  
83 examiner who investigated the complaint. [Each party to] The claimant  
84 and the insurance company involved in the dispute shall pay a filing

85 fee of [twenty] fifty dollars and one hundred dollars, respectively. The  
86 insurance company shall pay the consumer the undisputed amount of  
87 the claim upon written notification from the department that the  
88 complaint has been referred to arbitration. Such payment shall not  
89 affect any right of the consumer to pursue the disputed amount of the  
90 claim.

91 (2) The commissioner shall prepare a list of at least ten persons, who  
92 have not been employed by the department or an insurance company  
93 during the preceding twelve months, to serve as arbitrators in the  
94 settlement of such disputes. The arbitrators shall be members of any  
95 dispute resolution organization approved by the commissioner. One  
96 arbitrator shall be appointed to hear and decide each complaint.  
97 Appointment shall be based solely on the order of the list. If an  
98 arbitrator is unable to serve on a given day, or if either party objects to  
99 the arbitrator, then the next arbitrator on the list will be selected. The  
100 department shall schedule arbitration hearings as often, and in such  
101 locations, as it deems necessary. Parties to the dispute shall be  
102 provided written notice of the hearing, at least ten days prior to the  
103 hearing date. The commissioner may issue subpoenas on behalf of the  
104 arbitrator to compel the attendance of witnesses and the production of  
105 documents, papers and records relevant to the dispute. Decisions shall  
106 be made on the basis of the evidence presented at the arbitration  
107 hearing. Where the arbitrator believes that technical expertise is  
108 necessary to decide a case, he may consult with an independent expert  
109 recommended by the commissioner. The arbitrator and any  
110 independent technical expert shall be paid by the department on a per  
111 dispute basis as established by the commissioner. The arbitrator, as  
112 expeditiously as possible, but not later than fifteen days after the  
113 arbitration hearing, shall render a written decision based on the  
114 information gathered and disclose the findings and the reasons to the  
115 parties involved. The arbitrator shall award filing fees to the prevailing  
116 party. If the decision favors the consumer the decision shall provide  
117 specific and appropriate remedies including interest at the rate of ten  
118 per cent on the arbitration award concerning the disputed amount of  
119 the claim, retroactive to the date of payment for the undisputed

120 amount of the claim. The decision may include costs for loss of use and  
121 storage of the motor vehicle and shall specify a date for performance  
122 and completion of all awarded remedies. Notwithstanding any  
123 provision of the general statutes or any regulation to the contrary, the  
124 Insurance Department shall not amend, reverse, rescind, or revoke any  
125 decision or action of any arbitrator. The department shall contact the  
126 consumer within ten working days after the date for performance, to  
127 determine whether performance has occurred. Either party may make  
128 application to the superior court for the judicial district in which one of  
129 the parties resides or, when the court is not in session, any judge  
130 thereof for an order confirming, vacating, modifying or correcting any  
131 award, in accordance with the provisions of sections 52-417, 52-418, 52-  
132 419 and 52-420. If it is determined by the court that either party's  
133 position after review has been improved by at least ten per cent over  
134 that party's position after arbitration, the court, in its discretion, may  
135 grant to that party its costs and reasonable attorney's fees. No  
136 evidence, testimony, findings, or decision from the department  
137 arbitration procedure shall be admissible in any civil proceeding,  
138 except judicial review of the arbitrator's decision as contemplated by  
139 this subsection.

140 (3) The department shall maintain records of each dispute,  
141 including names of parties to the arbitration, the decision of the  
142 arbitrator, compliance, the appeal, if any, and the decision of the court.  
143 The department shall annually compile such statistics and send a copy  
144 to the committee of the General Assembly having cognizance of  
145 matters relating to insurance. The report shall be considered a public  
146 document.

147 (c) Notwithstanding the provisions of section 4-8, there shall be [a  
148 Division of Rate Review] divisions within the Insurance Department [,  
149 which division] that shall act on the commissioner's behalf and at the  
150 commissioner's direction in order to carry out the commissioner's  
151 responsibilities under this title with respect to [such matters] rate  
152 review. Subject to the provisions of sections 38a-663 to 38a-696,  
153 inclusive, the [division] divisions shall assist the commissioner in

154 reviewing rates and supplementary rate information filed with the  
155 department for compliance with statutory requirements and  
156 standards. The [division's staff] divisions' staffs shall include rating  
157 examiners with sufficient actuarial expertise. Upon the request of the  
158 commissioner, the [division] divisions shall review rates and  
159 supplementary rate information, and any suspected violation of the  
160 statutory requirements and standards of sections 38a-663 to 38a-696,  
161 inclusive, found pursuant to such review shall be referred to the  
162 commissioner for appropriate action. The [division] divisions may  
163 assist the commissioner in formalizing the commissioner's findings  
164 regarding such actions. The commissioner shall report to the joint  
165 standing committee of the General Assembly having cognizance of  
166 matters relating to insurance on or before January [15, 1988, and]  
167 fifteenth annually, [thereafter,] concerning (1) the number and type of  
168 reviews conducted by the property and casualty division in the prior  
169 calendar year, and (2) the percentage of increase or decrease in rates  
170 reviewed by the property and casualty division during the preceding  
171 calendar year, by line and subline of insurance.

172 (d) The directors and staff of [both the Division of Consumer Affairs  
173 and the Division of Rate Review] the divisions set forth in subsections  
174 (a) and (c) of this section shall be appointed by the commissioner  
175 under the provisions of chapter 67.

176 Sec. 3. Subsection (a) of section 38a-11 of the general statutes is  
177 repealed and the following is substituted in lieu thereof (*Effective*  
178 *October 1, 2009*):

179 (a) The commissioner shall demand and receive the following fees:  
180 (1) For the annual fee for each license issued to a domestic insurance  
181 company, one hundred dollars; (2) for receiving and filing annual  
182 reports of domestic insurance companies, twenty-five dollars; (3) for  
183 filing all documents prerequisite to the issuance of a license to an  
184 insurance company, one hundred seventy-five dollars, except that the  
185 fee for such filings by any health care center, as defined in section 38a-  
186 175, shall be one thousand one hundred dollars; (4) for filing any

187 additional paper required by law, fifteen dollars; (5) for each certificate  
188 of valuation, organization, reciprocity or compliance, twenty dollars;  
189 (6) for each certified copy of a license to a company, twenty dollars; (7)  
190 for each certified copy of a report or certificate of condition of a  
191 company to be filed in any other state, twenty dollars; (8) for  
192 amending a certificate of authority, one hundred dollars; (9) for each  
193 license issued to a rating organization, one hundred dollars. In  
194 addition, insurance companies shall pay any fees imposed under  
195 section 12-211; (10) a filing fee of twenty-five dollars for each initial  
196 application for a license made pursuant to section 38a-769; (11) with  
197 respect to insurance agents' appointments: (A) A filing fee of twenty-  
198 five dollars for each request for any agent appointment, except that no  
199 filing fee shall be payable for a request for agent appointment by an  
200 insurance company domiciled in a state or foreign country which does  
201 not require any filing fee for a request for agent appointment for a  
202 Connecticut insurance company; (B) a fee of forty dollars for each  
203 appointment issued to an agent of a domestic insurance company or  
204 for each appointment continued; and (C) a fee of [twenty] forty dollars  
205 for each appointment issued to an agent of any other insurance  
206 company or for each appointment continued, except that no fee shall  
207 be payable for an appointment issued to an agent of an insurance  
208 company domiciled in a state or foreign country which does not  
209 require any fee for an appointment issued to an agent of a Connecticut  
210 insurance company; (12) with respect to insurance producers: (A) An  
211 examination fee of seven dollars for each examination taken, except  
212 when a testing service is used, the testing service shall pay a fee of  
213 seven dollars to the commissioner for each examination taken by an  
214 applicant; (B) a fee of forty dollars for each license issued; (C) a fee of  
215 forty dollars per year, or any portion thereof, for each license renewed;  
216 and (D) a fee of forty dollars for any license renewed under the  
217 transitional process established in section 38a-784; (13) with respect to  
218 public adjusters: (A) An examination fee of seven dollars for each  
219 examination taken, except when a testing service is used, the testing  
220 service shall pay a fee of seven dollars to the commissioner for each  
221 examination taken by an applicant; and (B) a fee of one hundred

222 twenty-five dollars for each license issued or renewed; (14) with  
223 respect to casualty adjusters: (A) An examination fee of ten dollars for  
224 each examination taken, except when a testing service is used, the  
225 testing service shall pay a fee of ten dollars to the commissioner for  
226 each examination taken by an applicant; (B) a fee of forty dollars for  
227 each license issued or renewed; and (C) the expense of any  
228 examination administered outside the state shall be the responsibility  
229 of the entity making the request and such entity shall pay to the  
230 commissioner one hundred dollars for such examination and the  
231 actual traveling expenses of the examination administrator to  
232 administer such examination; (15) with respect to motor vehicle  
233 physical damage appraisers: (A) An examination fee of forty dollars  
234 for each examination taken, except when a testing service is used, the  
235 testing service shall pay a fee of forty dollars to the commissioner for  
236 each examination taken by an applicant; (B) a fee of forty dollars for  
237 each license issued or renewed; and (C) the expense of any  
238 examination administered outside the state shall be the responsibility  
239 of the entity making the request and such entity shall pay to the  
240 commissioner one hundred dollars for such examination and the  
241 actual traveling expenses of the examination administrator to  
242 administer such examination; (16) with respect to certified insurance  
243 consultants: (A) An examination fee of thirteen dollars for each  
244 examination taken, except when a testing service is used, the testing  
245 service shall pay a fee of thirteen dollars to the commissioner for each  
246 examination taken by an applicant; (B) a fee of two hundred dollars for  
247 each license issued; and (C) a fee of one hundred twenty-five dollars  
248 for each license renewed; (17) with respect to surplus lines brokers: (A)  
249 An examination fee of ten dollars for each examination taken, except  
250 when a testing service is used, the testing service shall pay a fee of ten  
251 dollars to the commissioner for each examination taken by an  
252 applicant; and (B) a fee of five hundred dollars for each license issued  
253 or renewed; (18) with respect to fraternal agents, a fee of forty dollars  
254 for each license issued or renewed; (19) a fee of thirteen dollars for  
255 each license certificate requested, whether or not a license has been  
256 issued; (20) with respect to domestic and foreign benefit societies shall

257 pay: (A) For service of process, twenty-five dollars for each person or  
258 insurer to be served; (B) for filing a certified copy of its charter or  
259 articles of association, five dollars; (C) for filing the annual report, ten  
260 dollars; and (D) for filing any additional paper required by law, three  
261 dollars; (21) with respect to foreign benefit societies: (A) For each  
262 certificate of organization or compliance, four dollars; (B) for each  
263 certified copy of permit, two dollars; and (C) for each copy of a report  
264 or certificate of condition of a society to be filed in any other state, four  
265 dollars; (22) with respect to reinsurance intermediaries: A fee of five  
266 hundred dollars for each license issued or renewed; (23) with respect  
267 to life settlement providers: (A) A filing fee of thirteen dollars for each  
268 initial application for a license made pursuant to section 38a-465a; and  
269 (B) a fee of twenty dollars for each license issued or renewed; (24) with  
270 respect to life settlement brokers: (A) A filing fee of thirteen dollars for  
271 each initial application for a license made pursuant to section 38a-465a;  
272 and (B) a fee of twenty dollars for each license issued or renewed; (25)  
273 with respect to preferred provider networks, a fee of two thousand five  
274 hundred dollars for each license issued or renewed; (26) with respect  
275 to rental companies, as defined in section 38a-799, a fee of forty dollars  
276 for each permit issued or renewed; (27) with respect to medical  
277 discount plan organizations licensed under section 38a-479rr, a fee of  
278 five hundred dollars for each license issued or renewed; (28) with  
279 respect to pharmacy benefits managers, an application fee of fifty  
280 dollars for each registration issued or renewed; (29) with respect to  
281 captive insurance companies, as defined in section 38a-91aa, a fee of  
282 three hundred dollars for each license issued or renewed; [and] (30)  
283 with respect to each duplicate license issued a fee of twenty-five  
284 dollars for each license issued; and (31) for each statement of  
285 acquisition of control of a domestic insurer submitted to the  
286 commissioner pursuant to section 38a-130, two thousand five hundred  
287 dollars.

288 Sec. 4. Section 38a-14a of the general statutes is repealed and the  
289 following is substituted in lieu thereof (*Effective October 1, 2009*):

290 (a) Subject to the limitation contained in this section and in addition

291 to the powers which the Insurance Commissioner has under sections  
292 38a-14 and 38a-15, as amended by this act, relating to the examination  
293 of insurance companies and health care centers doing business in this  
294 state, the commissioner shall have the power to order any insurance  
295 company registered under section 38a-135 or health care center to  
296 produce such records, books or other information in the possession of  
297 the insurance company or health care center or its affiliates as are  
298 reasonably necessary to ascertain the financial condition of such  
299 insurance company or health care center or to determine compliance  
300 with sections 38a-129 to 38a-140, inclusive. In the event such insurance  
301 company or health care center fails to comply with such order, the  
302 commissioner shall have the power to examine any such affiliate to  
303 obtain such information.

304 (b) The commissioner may engage the services of attorneys,  
305 actuaries, accountants and other experts not otherwise a part of the  
306 commissioner's staff, at the registered insurance company's or health  
307 care center's expense, as shall be reasonably necessary to assist in the  
308 conduct of the examination under subsection (a) of this section. All  
309 persons so engaged shall be under the direction and control of the  
310 commissioner and shall act in a purely advisory capacity.

311 (c) Each registered insurance company or health care center  
312 producing for examination records, books and papers pursuant to  
313 subsection (a) of this section shall be liable for and shall pay the  
314 expense of such examination in accordance with sections 38a-14 and  
315 38a-15, as amended by this act.

316 Sec. 5. Section 38a-15 of the general statutes is repealed and the  
317 following is substituted in lieu thereof (*Effective October 1, 2009*):

318 (a) The commissioner shall, as often as [he] the commissioner deems  
319 it expedient undertake a market conduct examination of the affairs of  
320 any insurance company, health care center or fraternal benefit society  
321 doing business in this state.

322 (b) To carry out the examinations under this section, the

323 commissioner may appoint, as market conduct examiners, one or more  
324 competent persons [, not officers or] who shall not be officers of,  
325 connected with or interested in any insurance company, health care  
326 center or fraternal benefit society, other than as a policyholder. In  
327 conducting the examination, the commissioner, [his] the  
328 commissioner's actuary or any examiner authorized by the  
329 commissioner may examine, under oath, the officers and agents of  
330 such an insurance company, health care center or fraternal benefit  
331 society and all persons deemed to have material information regarding  
332 the company's, center's or society's property or business. Each such  
333 company, center or society, its officers and agents, shall produce the  
334 books and papers, in its or their possession, relating to its business or  
335 affairs, and any other person may be required to produce any book or  
336 paper [, in his] in such person's custody, deemed to be relevant to the  
337 examination, for the inspection of the commissioner, [his] the  
338 commissioner's actuary or examiners, when required. The officers and  
339 agents of the company, center or association shall facilitate the  
340 examination and aid the examiners in making the same so far as it is in  
341 their power to do so.

342 (c) Each market conduct examiner shall make a full and true report  
343 of each market conduct examination made by [him] such examiner,  
344 which shall comprise only facts appearing upon the books, papers,  
345 records or documents of the examined company, center or society or  
346 ascertained from the sworn testimony of its officers or agents or of  
347 other persons examined under oath concerning its affairs. The  
348 examiner's report shall be presumptive evidence of the facts therein  
349 stated in any action or proceeding in the name of the state against the  
350 company, center or society, its officers or agents. [The] Before filing  
351 such report, the commissioner shall grant a hearing to the company,  
352 center or society examined, [before filing any such report,] and may  
353 withhold any such report from public inspection for such time as [he]  
354 the commissioner deems proper. The commissioner may, if [he] said  
355 commissioner deems it in the public interest, publish any such report,  
356 or the result of any such examination contained therein, in one or more  
357 newspapers of the state.

358 [(d) All the expense of any examination made under the authority of  
359 this section, other than examinations of domestic insurance companies,  
360 shall be paid by the company, center or society examined, and  
361 domestic insurance companies and other domestic entities examined  
362 outside the state shall pay the traveling and maintenance expenses of  
363 examiners.]

364 (d) (1) The commissioner may engage the services of attorneys,  
365 appraisers, independent actuaries, independent certified public  
366 accountants or other professionals and specialists to assist in  
367 conducting the examinations under this section as examiners, the cost  
368 of which shall be borne by the company that is the subject of the  
369 examination.

370 (2) No cause of action shall arise nor shall any liability be imposed  
371 against the commissioner, the commissioner's authorized  
372 representatives or any examiner appointed by the commissioner for  
373 any statements made or conduct performed in good faith while  
374 carrying out the provisions of this section.

375 (3) No cause of action shall arise nor shall any liability be imposed  
376 against any person for the act of communicating or delivering  
377 information or data to the commissioner or the commissioner's  
378 authorized representative or examiner pursuant to an examination  
379 made under this section, if such act of communication or delivery was  
380 performed in good faith and without fraudulent intent or the intent to  
381 deceive.

382 (4) This section shall not abrogate or modify any common law or  
383 statutory privilege or immunity heretofore enjoyed by any person  
384 identified in subdivision (2) of this subsection.

385 (5) A person identified in subdivision (2) of this subsection shall be  
386 entitled to an award of attorney's fees and costs if such person is the  
387 prevailing party in a civil cause of action for libel, slander or any other  
388 relevant tort arising out of activities in carrying out the provisions of  
389 this section and the party bringing the action was not substantially

390 justified in doing so. For the purposes of this section, a proceeding is  
391 "substantially justified" if it had a reasonable basis in law or fact at the  
392 time that it was initiated.

393 (e) Notwithstanding subdivision (1) of subsection (d) of this section,  
394 no domestic insurance company or other domestic entity subject to  
395 examination under this section shall pay as costs associated with the  
396 examination the salaries, fringe benefits, traveling and maintenance  
397 expenses of examining personnel of the Insurance Department  
398 engaged in such examination if such domestic company or entity is  
399 otherwise liable to an assessment levied under section 38a-47, except  
400 that a domestic insurance company or other domestic entity shall pay  
401 the traveling and maintenance expenses of examining personnel of the  
402 Insurance Department when such company or entity is examined  
403 outside the state.

404 (f) Nothing in this section shall be construed to prevent or prohibit  
405 the commissioner from disclosing the content of an examination  
406 report, preliminary examination report or results, or any matter  
407 relating thereto, to the Insurance Department of this or any other state  
408 or country, or to law enforcement officials of this or any other state or  
409 to any agency of the federal government at any time, as long as such  
410 agency or office receiving the report or matters relating thereto agrees  
411 in writing to hold such report or matters confidential.

412 (g) All working papers, recorded information, documents and  
413 copies thereof produced by, obtained by or disclosed to the  
414 commissioner or any other person in the course of an examination  
415 made under this section shall be given confidential treatment, shall not  
416 be subject to subpoena and shall not be made public by the  
417 commissioner or any other person, except to the extent provided in  
418 subsection (f) of this section. Access to such working papers, recorded  
419 information, documents and copies may be granted by the  
420 commissioner to the National Association of Insurance Commissioners  
421 as long as it agrees, in writing, to hold such working papers, recorded  
422 information, documents and copies confidential.

423 Sec. 6. Section 38a-430 of the general statutes is repealed and the  
424 following is substituted in lieu thereof (*Effective October 1, 2009*):

425 (a) No life insurance or annuity policy or contract shall be delivered  
426 or issued for delivery to any person in this state, nor shall any  
427 application, rider or endorsement be used in connection therewith,  
428 until a copy of the form thereof shall have been filed with and  
429 approved by the commissioner. The commissioner shall adopt  
430 regulations, in accordance with the provisions of chapter 54,  
431 establishing a procedure for review of such policies. The commissioner  
432 shall issue [an order] a decision disapproving the use of any such form  
433 at any time if it does not comply with the requirements of law, or if it  
434 contains a provision or provisions which are unfair or deceptive or  
435 which encourage misrepresentation of the policy. The commissioner  
436 shall specify the reason for his disapproval. The provisions of section  
437 38a-19 shall apply to any such [order] decision issued by the  
438 commissioner.

439 (b) The commissioner may, as a condition of approval of a policy  
440 form, require the insurer to provide disclosure notices, illustrations or  
441 other explanatory materials to a policyholder at the time of sale. The  
442 commissioner may require revisions to policy forms and related  
443 advertising and sales materials if the commissioner believes such  
444 revisions are required to protect policyholders. The commissioner may  
445 issue guidelines for requirements for disclosure notices, illustrations or  
446 other explanatory materials said commissioner deems necessary to  
447 protect policyholders.

448 [(b)] (c) Nothing in this chapter shall preclude the issuance of a life  
449 insurance contract, including, but not limited to, a long-term care  
450 policy as provided in section 38a-458, which includes an optional  
451 health insurance rider, provided [,] the optional health insurance rider  
452 [must be] is filed with and approved by the Insurance Commissioner  
453 pursuant to section 38a-481, as amended by this act. Any company  
454 offering such policies for sale in this state shall be licensed to sell  
455 health insurance in this state pursuant to the provisions of section 38a-

456 41.

457 Sec. 7. Section 38a-469 of the general statutes is repealed and the  
458 following is substituted in lieu thereof (*Effective October 1, 2009*):

459 As used in this title, unless the context otherwise requires or a  
460 different meaning is specifically prescribed, "health insurance" policy  
461 means insurance providing benefits due to illness or injury, resulting  
462 in loss of life, loss of earnings, or expenses incurred, and includes the  
463 following types of coverage: (1) Basic hospital expense coverage; (2)  
464 basic medical-surgical expense coverage; (3) hospital confinement  
465 indemnity coverage; (4) major medical expense coverage; (5) disability  
466 income protection coverage; (6) accident only coverage; (7) long term  
467 care coverage; (8) specified accident coverage; (9) Medicare  
468 supplement coverage; (10) limited benefit health coverage; (11)  
469 hospital or medical service plan contract; (12) hospital and medical  
470 coverage provided to subscribers of a health care center; (13) specified  
471 disease coverage; (14) TriCare supplement coverage; (15) travel health  
472 coverage; and (16) single service ancillary health coverage, including,  
473 but not limited to, dental, vision or prescription drug coverage.

474 Sec. 8. Section 38a-481 of the general statutes is repealed and the  
475 following is substituted in lieu thereof (*Effective October 1, 2009*):

476 (a) (1) No individual health insurance policy shall be delivered or  
477 issued for delivery to any person in this state, nor shall any  
478 application, rider or endorsement be used in connection with such  
479 policy, until a copy of the form thereof and of the classification of risks  
480 and the premium rates have been filed with the commissioner. The  
481 commissioner shall adopt regulations, in accordance with chapter 54,  
482 to establish a procedure for reviewing such policies. The commissioner  
483 shall disapprove the use of such form at any time if it does not comply  
484 with the requirements of law, or if it contains a provision or provisions  
485 [which] that are unfair or deceptive or [which] that encourage  
486 misrepresentation of the policy. The commissioner shall notify, in  
487 writing, the insurer [which] that has filed any such form of the  
488 commissioner's disapproval, specifying the reasons for disapproval,

489 and [ordering] communicating that no such insurer shall deliver or  
490 issue for delivery to any person in this state a policy on or containing  
491 such form. The provisions of section 38a-19 shall apply to such [orders]  
492 notifications of disapprovals.

493 (2) The commissioner may, as a condition of approval of a policy  
494 form, require the insurer to provide disclosure notices, illustrations or  
495 other explanatory materials to a policyholder at the time of sale. The  
496 commissioner may require revisions to policy forms and related  
497 advertising and sales materials if the commissioner believes such  
498 revisions are required to protect policyholders. The commissioner may  
499 issue guidelines for requirements for disclosure notices, illustrations or  
500 other explanatory materials said commissioner deems necessary to  
501 protect policyholders.

502 (b) No rate filed under the provisions of subsection (a) of this  
503 section shall be effective until the expiration of thirty days after it has  
504 been filed or unless sooner approved by the commissioner in  
505 accordance with regulations adopted pursuant to this subsection. The  
506 commissioner shall adopt regulations, in accordance with chapter 54,  
507 to prescribe standards to insure that such rates shall not be excessive,  
508 inadequate or unfairly discriminatory. The commissioner may  
509 disapprove such rate within thirty days after it has been filed if it fails  
510 to comply with such standards, except that no rate filed under the  
511 provisions of subsection (a) of this section for any Medicare  
512 supplement policy shall be effective unless approved in accordance  
513 with section 38a-474.

514 (c) No insurance company, fraternal benefit society, hospital service  
515 corporation, medical service corporation, health care center or other  
516 entity which delivers or issues for delivery in this state any Medicare  
517 supplement policies or certificates shall incorporate in its rates or  
518 determinations to grant coverage for Medicare supplement insurance  
519 policies or certificates any factors or values based on the age, gender,  
520 previous claims history or the medical condition of any person covered  
521 by such policy or certificate, except for plans "H" to "J", inclusive, as

522 provided in section 38a-495b. In plans "H" to "J", inclusive, previous  
523 claims history and the medical condition of the applicant may be used  
524 in determinations to grant coverage under Medicare supplement  
525 policies and certificates issued prior to January 1, 2006.

526 (d) Rates on a particular policy form [will] shall not be deemed  
527 excessive if the insurer has filed a loss ratio guarantee with the  
528 Insurance Commissioner [which] that meets the requirements of  
529 subsection (e) of this section, provided (1) the form of such loss ratio  
530 guarantee has been explicitly approved by the Insurance  
531 Commissioner, and (2) the current expected lifetime loss ratio is not  
532 more than five per cent less than the filed lifetime loss ratio as certified  
533 by an actuary. The insurer shall withdraw the policy form if the  
534 commissioner determines that the lifetime loss ratio will not be met.  
535 Rates also [will] shall not be deemed excessive if the insurer complies  
536 with the terms of the loss ratio guarantee. The Insurance  
537 Commissioner may adopt regulations, in accordance with chapter 54,  
538 to [assure] ensure that the use of a loss ratio guarantee does not  
539 constitute an unfair practice.

540 (e) Premium rates shall be deemed approved upon filing with the  
541 Insurance Commissioner if the filing is accompanied by a loss ratio  
542 guarantee. The loss ratio guarantee shall be in writing, signed by an  
543 officer of the insurer, and shall contain as a minimum the following:

544 (1) A recitation of the anticipated lifetime and durational target loss  
545 ratios contained in the original actuarial memorandum filed with the  
546 policy form when it was originally approved;

547 (2) A guarantee that the actual Connecticut loss ratios for the  
548 experience period in which the new rates take effect and for each  
549 experience period thereafter until any new rates are filed will meet or  
550 exceed the loss ratios referred to in subdivision (1) of this subsection. If  
551 the annual earned premium volume in Connecticut under the  
552 particular policy form is less than one million dollars and therefore not  
553 actuarially credible, the loss ratio guarantee will be based on the actual  
554 nation-wide loss ratio for the policy form. If the aggregate earned

555 premium for all states is less than one million dollars, the experience  
556 period will be extended until the end of the calendar year in which one  
557 million dollars of earned premium is attained;

558 (3) A guarantee that the actual Connecticut or nation-wide loss ratio  
559 results, as the case may be, for the experience period at issue will be  
560 independently audited by a certified public accountant or a member of  
561 the American Academy of Actuaries at the insurer's expense. The audit  
562 shall be done in the second quarter of the year following the end of the  
563 experience period and the audited results must be reported to the  
564 Insurance Commissioner not later than June thirtieth following the end  
565 of the experience period;

566 (4) A guarantee that affected Connecticut policyholders will be  
567 issued a proportional refund, which will be based on the premiums  
568 earned, of the amount necessary to bring the actual loss ratio up to the  
569 anticipated loss ratio referred to in subdivision (1) of this subsection. If  
570 nation-wide loss ratios are used, the total amount refunded in  
571 Connecticut shall equal the dollar amount necessary to achieve the loss  
572 ratio standards multiplied by the total premium earned from all  
573 Connecticut policyholders who will receive refunds and divided by  
574 the total premium earned in all states on the policy form. The refund  
575 shall be made to all Connecticut policyholders who are insured under  
576 the applicable policy form as of the last day of the experience period  
577 and whose refund would equal two dollars or more. The refund shall  
578 include interest, at six per cent, from the end of the experience period  
579 until the date of payment. Payment shall be made during the third  
580 quarter of the year following the experience period for which a refund  
581 is determined to be due;

582 (5) A guarantee that refunds less than two dollars will be  
583 aggregated by the insurer. The insurer shall deposit such amount in a  
584 separate interest-bearing account in which all such amounts shall be  
585 deposited. At the end of each calendar year each such insurer shall  
586 donate such amount to The University of Connecticut Health Center;

587 (6) A guarantee that the insurer, if directed by the Insurance

588 Commissioner, shall withdraw the policy form and cease the issuance  
589 of new policies under the form in this state if the applicable loss ratio  
590 exceeds the durational target loss ratio for the experience period by  
591 more than twenty per cent, provided the calculations are based on at  
592 least two thousand policyholder-years of experience either in  
593 Connecticut or nation-wide.

594 (f) For the purposes of this section:

595 (1) "Loss ratio" means the ratio of incurred claims to earned  
596 premiums by the number of years of policy duration for all combined  
597 durations; and

598 (2) "Experience period" means the calendar year for which a loss  
599 ratio guarantee is calculated.

600 (g) Nothing in this chapter shall preclude the issuance of an  
601 individual health insurance policy which includes an optional life  
602 insurance rider, provided the optional life insurance rider must be  
603 filed with and approved by the Insurance Commissioner pursuant to  
604 section 38a-430, as amended by this act. Any company offering such  
605 policies for sale in this state shall be licensed to sell life insurance in  
606 this state pursuant to the provisions of section 38a-41.

607 (h) No insurance company, fraternal benefit society, hospital service  
608 corporation, medical service corporation, health care center or other  
609 entity [which] that delivers, issues for delivery, amends, renews or  
610 continues an individual health insurance policy in this state on or after  
611 October 1, 2003, [may] shall (1) move an insured individual from a  
612 standard underwriting classification to a substandard underwriting  
613 classification after the policy is issued; or (2) increase premium rates  
614 due to the claim experience or health status of an individual who is  
615 insured under the policy, except that the entity may increase premium  
616 rates for all individuals in an underwriting classification due to the  
617 claim experience or health status of the underwriting classification as a  
618 whole.

619 Sec. 9. Section 38a-495b of the general statutes is repealed and the  
620 following is substituted in lieu thereof (*Effective from passage*):

621 (a) As used in sections 38a-473, 38a-474 and 38a-481, subsection (l)  
622 of section 38a-495a, sections 38a-495c and 38a-513 and this section,  
623 "Medicare" means the Health Insurance for the Aged Act, Title XVIII of  
624 the Social Security Amendments of 1965, as amended (Title I, Part I of  
625 P.L. 89-97). For policies or certificates delivered or issued for delivery  
626 to any resident of this state who is eligible for Medicare, prior to July  
627 30, 1992, "Medicare supplement policy" means any individual or group  
628 health insurance policy or certificate delivered or issued for delivery to  
629 any resident of the state who is eligible for Medicare, except any long-  
630 term care policy as defined in sections 38a-501 and 38a-528. For  
631 policies or certificates delivered or issued for delivery to any resident  
632 on or after July 30, 1992, "Medicare supplement policy" means (A) a  
633 group or individual policy of accident and sickness insurance, or (B) a  
634 subscriber contract of hospital and medical service corporations or  
635 health care centers, other than a policy issued pursuant to a contract  
636 under Section 1876 or Section 1833 of the federal Social Security Act (42  
637 USC Section 1395 et seq.), or (C) an issued policy under a  
638 demonstration project authorized pursuant to amendments to the  
639 federal Social Security Act, which is advertised, marketed or designed  
640 primarily as a supplement to reimbursements under Medicare for the  
641 hospital, medical or surgical expenses of persons eligible for Medicare.

642 (b) In accordance with the regulations adopted pursuant to section  
643 38a-495a, on and after July 1, 2005, there [are] shall be standardized  
644 Medicare supplement insurance policies or certificates as designated  
645 [as plans "A" to "L", inclusive] by the Centers for Medicare and  
646 Medicaid Services.

647 Sec. 10. Section 38a-513 of the general statutes is repealed and the  
648 following is substituted in lieu thereof (*Effective October 1, 2009*):

649 (a) (1) No group health insurance policy [, as defined by the  
650 commissioner,] or certificate shall be issued or delivered in this state  
651 unless a copy of the form for such policy or certificate has been

652 submitted to and approved by the commissioner under the regulations  
653 adopted pursuant to this section. The commissioner shall adopt  
654 regulations, in accordance with chapter 54, concerning the provisions,  
655 submission and approval of such policies and certificates and  
656 establishing a procedure for reviewing such policies and certificates. [If  
657 the commissioner issues an order disapproving the use of such form,  
658 the] The commissioner shall disapprove the use of such form at any  
659 time if it does not comply with the requirements of law, or if it  
660 contains a provision or provisions that are unfair or deceptive or that  
661 encourage misrepresentation of the policy. The commissioner shall  
662 notify, in writing, the insurer that has filed any such form of the  
663 commissioner's disapproval, specifying the reasons for disapproval,  
664 and communicating that no such insurer shall deliver or issue for  
665 delivery to any person in this state a policy on or containing such form.  
666 The provisions of section 38a-19 shall apply to such [order]  
667 notifications of disapprovals.

668 (2) The commissioner may, as a condition of approval of a policy  
669 form, require the insurer to provide disclosure notices, illustrations or  
670 other explanatory materials to a policyholder at the time of sale. The  
671 commissioner may require revisions to policy forms and related  
672 advertising and sales materials if the commissioner believes such  
673 revisions are required to protect policyholders. The commissioner may  
674 issue guidelines for disclosure notice requirements said commissioner  
675 deems necessary to protect policyholders.

676 (b) No insurance company, fraternal benefit society, hospital service  
677 corporation, medical service corporation, health care center or other  
678 entity [which] that delivers or issues for delivery in this state any  
679 Medicare supplement policies or certificates shall incorporate in its  
680 rates or determinations to grant coverage for Medicare supplement  
681 insurance policies or certificates any factors or values based on the age,  
682 gender, previous claims history or the medical condition of any person  
683 covered by such policy or certificate, except for plans "H" to "J",  
684 inclusive, as provided in section 38a-495b, as amended by this act. In  
685 plans "H" to "J", inclusive, previous claims history and the medical

686 condition of the applicant may be used in determinations to grant  
687 coverage under Medicare supplement policies and certificates issued  
688 prior to January 1, 2006.

689 (c) Nothing in this chapter shall preclude the issuance of a group  
690 health insurance policy which includes an optional life insurance rider,  
691 provided the optional life insurance rider must be filed with and  
692 approved by the Insurance Commissioner pursuant to section 38a-430,  
693 as amended by this act. Any company offering such policies for sale in  
694 this state shall be licensed to sell life insurance in this state pursuant to  
695 the provisions of section 38a-41.

696 (d) Not later than January 1, 2009, the commissioner shall adopt  
697 regulations, in accordance with chapter 54, to establish minimum  
698 standards for benefits in group specified disease policies, certificates,  
699 riders, endorsements and benefits.

700 Sec. 11. Section 38a-519 of the general statutes is repealed and the  
701 following is substituted in lieu thereof (*Effective October 1, 2009*):

702 No group health insurance policy [which] that provides disability  
703 income protection coverage, delivered, [or] issued for delivery,  
704 amended, [or] renewed [,] or continued in this state, on or after  
705 [January 1, 1976] October 1, 2009, and no application, rider or  
706 endorsement used in connection therewith shall contain an offset  
707 proviso [. No such policy in effect on January 1, 1976, and no  
708 application, rider or endorsement used in connection therewith shall  
709 after January 1, 1981, contain an offset proviso. For the purposes of this  
710 section, an "offset proviso" means any provision of an insurance policy  
711 which allows the insurer to reduce his liability for loss or expense from  
712 sickness or from bodily injury of the insured by reason of any increase  
713 in the disability benefits on or after the date a claim commences under  
714 any such policy] for benefits other than those payable from other  
715 sources as a result of the disability. No offset shall be changed to reflect  
716 any increase in other disability benefits that occur on or after the date a  
717 claim commences under such policy.

718 Sec. 12. Subsection (k) of section 38a-660 of the general statutes is  
719 repealed and the following is substituted in lieu thereof (*Effective*  
720 *October 1, 2009*):

721 (k) To further the enforcement of this section and to determine the  
722 eligibility of any licensee, the commissioner may, as often as [he] the  
723 commissioner deems necessary, examine the books and records of any  
724 such licensee, the cost of which shall be borne by the licensee.

725 Sec. 13. Subdivision (15) of section 38a-816 of the general statutes is  
726 repealed and the following is substituted in lieu thereof (*Effective*  
727 *October 1, 2009*):

728 (15) (A) Failure by an insurer, or any other entity responsible for  
729 providing payment to a health care provider pursuant to an insurance  
730 policy, to pay accident and health claims, including, but not limited to,  
731 claims for payment or reimbursement to health care providers, within  
732 the time periods set forth in subparagraph (B) of this subdivision,  
733 unless the Insurance Commissioner determines that a legitimate  
734 dispute exists as to coverage, liability or damages or that the claimant  
735 has fraudulently caused or contributed to the loss. Any insurer, or any  
736 other entity responsible for providing payment to a health care  
737 provider pursuant to an insurance policy, who fails to pay such a claim  
738 or request within the time periods set forth in subparagraph (B) of this  
739 subdivision shall pay the claimant or health care provider the amount  
740 of such claim plus interest at the rate of fifteen per cent per annum, in  
741 addition to any other penalties which may be imposed pursuant to  
742 sections 38a-11, 38a-25, 38a-41 to 38a-53, inclusive, 38a-57 to 38a-60,  
743 inclusive, 38a-62 to 38a-64, inclusive, 38a-76, 38a-83, 38a-84, 38a-117 to  
744 38a-124, inclusive, 38a-129 to 38a-140, inclusive, 38a-146 to 38a-155,  
745 inclusive, 38a-283, 38a-288 to 38a-290, inclusive, 38a-319, 38a-320, 38a-  
746 459, 38a-464, 38a-815 to 38a-819, inclusive, 38a-824 to 38a-826,  
747 inclusive, and 38a-828 to 38a-830, inclusive. Whenever the interest due  
748 a claimant or health care provider pursuant to this section is less than  
749 one dollar, the insurer shall deposit such amount in a separate interest-  
750 bearing account in which all such amounts shall be deposited. At the

751 end of each calendar year each such insurer shall donate such amount  
752 to The University of Connecticut Health Center.

753 (B) Each insurer, or other entity responsible for providing payment  
754 to a health care provider pursuant to an insurance policy subject to this  
755 section, shall pay claims not later than forty-five days after receipt by  
756 the insurer of the claimant's proof of loss form or the health care  
757 provider's request for payment filed in accordance with the insurer's  
758 practices or procedures, except that when there is a deficiency in the  
759 information needed for processing a claim, as determined in  
760 accordance with section 38a-477, the insurer shall (i) send written  
761 notice to the claimant or health care provider, as the case may be, of all  
762 alleged deficiencies in information needed for processing a claim not  
763 later than thirty days after the insurer receives a claim for payment or  
764 reimbursement under the contract, and (ii) pay claims for payment or  
765 reimbursement under the contract not later than thirty days after the  
766 insurer receives the information requested.

767 (C) As used in this subdivision, "health care provider" means (i) a  
768 person licensed to provide health care services under chapter 368d,  
769 chapter 368v, chapters 370 to 373, inclusive, 375 to 383c, inclusive, 384a  
770 to 384c, inclusive, or chapter 400j, and (ii) a person who holds an  
771 equivalent license from any other state.

772 Sec. 14. Subsection (d) of section 38a-91bb of the general statutes is  
773 repealed and the following is substituted in lieu thereof (*Effective*  
774 *October 1, 2009*):

775 (d) (1) Each captive insurance company shall pay to the  
776 commissioner a nonrefundable fee of eight hundred dollars for  
777 examining, investigating and processing its application for a license. [,  
778 and the] The commissioner may retain legal, financial and examination  
779 services from outside the department for the licensing and financial  
780 oversight of a captive insurance company, the reasonable cost of which  
781 may be charged against [the applicant] such company. The provisions  
782 of subdivisions (2) to (5), inclusive, of subsection (k) of section 38a-14  
783 shall apply to [examinations, investigations and processing conducted

784 under] the services retained pursuant to this [section] subsection.

785 (2) Each captive insurance company shall pay a license fee for the  
 786 first year of licensure and a renewal fee for each year thereafter as set  
 787 forth in section 38a-11, as amended by this act.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2009</i>	38a-8(d)
Sec. 2	<i>from passage</i>	38a-9
Sec. 3	<i>October 1, 2009</i>	38a-11(a)
Sec. 4	<i>October 1, 2009</i>	38a-14a
Sec. 5	<i>October 1, 2009</i>	38a-15
Sec. 6	<i>October 1, 2009</i>	38a-430
Sec. 7	<i>October 1, 2009</i>	38a-469
Sec. 8	<i>October 1, 2009</i>	38a-481
Sec. 9	<i>from passage</i>	38a-495b
Sec. 10	<i>October 1, 2009</i>	38a-513
Sec. 11	<i>October 1, 2009</i>	38a-519
Sec. 12	<i>October 1, 2009</i>	38a-660(k)
Sec. 13	<i>October 1, 2009</i>	38a-816(15)
Sec. 14	<i>October 1, 2009</i>	38a-91bb(d)

**Statement of Legislative Commissioners:**

The last sentences of sections 6(b) and 8 (a)(2) were rewritten for internal consistency.

**INS**      *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

### **OFA Fiscal Note**

#### **State Impact:**

Agency Affected	Fund-Effect	FY 10 \$	FY 11 \$
Insurance Dept.	GF - Revenue Gain	\$7.3 million	\$1.2 million
Insurance Dept.	GF - Revenue Gain	Potential Significant	Potential Significant

Note: GF=General Fund

#### **Municipal Impact:** None

#### **Explanation**

This bill doubles the Department of Insurance (DOI) non-domestic company agent appointment fees, resulting in a revenue gain to the General Fund (GF) of approximately \$7.3 million in FY 10 and approximately \$1.2 million in FY 11. It also doubles DOI external arbitration review (review) filing fees for insurers and claimants, resulting in a potential revenue gain to the GF that, when added to the potential revenue gain to the GF from the new fee of \$2,500 for submittal to DOI of acquisition of control of a domestic insurer, could be significant.

Sec. 3 (a) 11 (C) doubles insurance agent appointment fees for non-domestic insurance companies (foreign companies) from \$20 to \$40 per agent. This results in a \$7.3 million revenue gain in even fiscal years and \$1.2 million in odd fiscal years from this larger appointment fee. Newly appointed agents pay this fee on a quarterly basis and then every two years on the even fiscal years. DOI collected \$14,691,331 for the GF from all agent appointment fees in FY 08.

Sec. 2 (b) 1 doubles the filing fees to claimants, from \$20 to \$40, and insurers, from \$50 to \$100, involved in a dispute related to automobile liability that is referred by DOI for review. DOI collected \$61,466 for

the GF in fees for legal and court services in FY 08 and project to collect \$64,000 in FY 09. It is unknown what portion of this amount is associated with automobile claim review. Revenue in the GF will increase subject to the number of filings for review following passage of the bill.

Sec. 3 (a) 31 creates a new fee of \$2,500 for the submittal to DOI of the acquisition of control of a domestic insurer. Revenue in the GF will increase subject to the number of submittals following the October 1, 2009 effective date.

### ***The Out Years***

The ongoing fiscal impact to the GF identified above would continue into the future subject to the number of foreign agent appointment fees, automobile claim review filings, and submittals of acquisition of control of a domestic insurance company collected by DOI.

**OLR Bill Analysis****sSB 823*****AN ACT CONCERNING REVISIONS TO THE INSURANCE STATUTES.*****SUMMARY:**

This bill makes changes in various insurance statutes. It:

1. subjects to state health insurance laws and regulations (a) travel health coverage and (b) single service ancillary health coverage, including dental, vision, or prescription drug coverage (§ 7);
2. specifies that the health insurance claim prompt pay requirements (see BACKGROUND) apply to both Connecticut-licensed health care providers and providers holding equivalent licensure from another state, to conform the statute to Attorney General Opinion 2008-15 (§ 13);
3. increases the filing fee for arbitrating disputes between auto insurers and claimants concerning certain private passenger auto insurance claims from \$20 to \$100 for an insurer and \$50 for a claimant (§ 2);
4. increases the fee an out-of-state insurer pays to appoint an agent to act on its behalf from \$20 to \$40 (§ 3);
5. establishes a \$2,500 fee for filing Form A (i.e., the legally-required statement about acquiring control of a Connecticut insurer) (§ 3);
6. revises the market conduct examination law with respect to costs, immunity, and confidentiality (see MARKET CONDUCT EXAMINATIONS) (§ 5);

7. expands the list of regulated entities for which the insurance commissioner may hire financial examination consultants to include any entity that must be licensed by, or registered with, the Insurance Department (§§ 1 and 14);
8. authorizes the commissioner to (a) order a health care center (i.e., HMO) to produce books, records, and other information it or an affiliate has and the department needs to conduct a financial or other examination of the company, a power he has with respect to insurers, and (b) examine an HMO's affiliate if the HMO fails to comply with the order (§ 4);
9. requires an HMO to pay costs related to the department's examination of it, including costs to hire consultants to assist in the examination (§ 4); and
10. recharacterizes the commissioner's disapproval of life and health insurance policy and related forms as a decision, rather than an order, but continues to treat the decision as an order for purposes of appeals and hearings related to it (§§ 6 and 8).

The bill authorizes the commissioner to:

1. as a condition of approving a life or health insurance policy or related form, require an insurer to provide a policyholder, at the time of sale, disclosure notices, illustrations, or other materials (§§ 6, 8, and 10);
2. issue guidelines for notices, illustrations, and other materials he deems necessary (§§ 6, 8, and 10);
3. require life and health insurers to make changes in policy forms and related advertising and sales material that he finds necessary to protect consumers (§§ 6, 8, and 10);
4. disapprove a group health insurance policy or certificate at any time if it (a) does not comply with applicable laws, (b) contains unfair or deceptive provisions, or (c) encourages policy

misrepresentation (§ 10); and

5. require a surety bail bond agent licensee to pay the cost of the commissioner's examination of his or her books and records, which the law authorizes him to do (§ 12).

The bill also:

1. amends the statutory description of the Insurance Department to remove obsolete references (§ 2);
2. removes an obsolete reference in the Medicare supplement law (§ 9);
3. rewords the law regarding a long-term disability policy's offset provision to make it more understandable and applies it to policies continued in Connecticut on and after October 1, 2009 (it already applies to policies delivered, issued, amended, or renewed here) (§ 11); and
4. makes other technical and conforming changes.

EFFECTIVE DATE: October 1, 2009, except for the increased arbitration filing fee, revised organizational structure description, and deletion of an obsolete Medicare supplement plan reference, which are effective upon passage.

## **§ 5 — MARKET CONDUCT EXAMINATIONS**

A market conduct examination is an Insurance Department's audit of a company licensed to do business in Connecticut to determine compliance with applicable state laws and regulations. It is separate and distinct from a financial examination, but may be conducted at the same time.

### **Costs**

By law, the company being examined must pay examination costs. The bill specifies that these include the cost for the department to hire consultants to assist with the examination.

The bill exempts a Connecticut company under examination from paying the salaries, fringe benefits, travel, and maintenance expenses of the department's examining personnel if the company pays assessments under law to the Insurance Department toward the department's operating expenses.

By law, and unchanged by the bill, a Connecticut company under examination must pay the examiner's travel and maintenance expenses when the department examines the company outside of Connecticut.

### ***Immunity***

The bill specifies that no cause of action or liability accrues against certain activities of specified people if those activities were performed in good faith.

Specifically, no cause of action or liability accrues against the commissioner, his authorized representatives, or appointed examiners for statements made or conduct performed in good faith while carrying out market conduct action. And no cause of action or liability accrues against any person communicating or delivering information to the commissioner, his representative, or examiner during an examination if the communication or delivery is performed in good faith and without fraudulent intent or the intent to deceive.

If someone files a civil action for libel, slander, or any other relevant tort arising out of examination activities against the commissioner, his authorized representative, or an appointed examiner, the bill entitles the commissioner or other person to an award of attorney's fees and costs if (1) he or she prevails and (2) the party bringing the action was not substantially justified in doing so. The bill defines a proceeding as "substantially justified" if it had a reasonable basis in law or fact at the time it was initiated.

The bill states that it does not abrogate or modify any common law or statutory privilege or immunity the people mentioned above currently enjoy.

***Confidentiality***

The bill makes working papers, recorded information, and documents, and copies of these, produced or obtained by, or disclosed to, the commissioner or any other person during a market conduct examination confidential and not subject to subpoena. The bill prohibits the commissioner or any other person from making them public, except the commissioner may grant the National Association of Insurance Commissioners access, if it agrees in writing to keep them confidential.

The bill also authorizes the commissioner to share an examination report, a preliminary report or results, or any related matter, with other state, federal, and international regulatory agencies and law enforcement authorities, if the recipient agrees in writing to keep the report or matters confidential.

**BACKGROUND*****Prompt Claim Payment Requirements***

By law, an insurer or other entity responsible for paying health and accident claims must pay a clean claim, including those payable to a health care provider, within 45 days of receiving it (CGS § 38a-816(15)). A claim is considered “clean” if it is submitted with all information required by law (CGS § 38a-477).

If a claim contains a deficiency, the entity must (1) send written notice to the claimant or health care provider, as the case may be, of all alleged deficiencies within 30 days of receiving the claim. The entity must process the claim within 30 days of receiving the corrected claim. The entity must add 15% interest if payment is late.

The prompt pay law defines “health care provider” as a physician, surgeon, chiropractor, naturopath, podiatrist, athletic trainer, physical therapist, occupational therapist, alcohol and drug counselor, radiologist, midwife, nurse, nurse's aide, dentist, dental hygienist, optometrist, optician, respiratory care practitioner, perfusionist, pharmacist, psychologist, marital and family therapist, clinical social

worker, professional counselor, massage therapist, dietician-nutritionist, acupuncturist, emergency medical service technician (EMT), and licensed health care institution. Licensed health care institution includes a hospital; residential care home; health care facility for the handicapped; nursing home; rest home; home health care agency; homemaker-home health aide agency; mental health facility; substance abuse treatment facility; student infirmary; an EMT organization; a facility providing services for the prevention, diagnosis, and treatment of human health conditions; and a Medicaid-certified residential facility for the mentally retarded.

**Related Bills**

**sSB 47.** The Insurance and Real Estate Committee favorably reported sSB 47 (File 176), which prohibits an entity, more than one year after receiving a “clean claim,” from canceling, denying, or demanding a refund of payment for an authorized service paid in error because of an administrative or eligibility mistake. (It is unclear if this prohibition applies to all claims subject to the prompt payment law.)

**sHB 6354.** The Insurance and Real Estate Committee favorably reported sHB 6354 (File 260), which makes changes in, and adds, requirements for surety bail bond agents. As with this bill, sHB 6354 requires an agent to pay the cost of the commissioner’s examination of his or her books and records.

**sSB 716.** The Labor and Public Employees Committee favorably reported sSB 716 (File 136), which bans long term disability insurance policies, certificates, and related forms from offsetting (reducing) benefits payable by the amount an insured receives under a Social Security disability claim. As with current law, this bill permits such an offset, but prohibits an insurer from increasing the amount of the offset over time.

**COMMITTEE ACTION**

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea     18     Nay   0     (03/12/2009)